2005

Medical Plan

Information

Department of Administration • State Personnel Division • Room 125 • Mitchell Building

PO Box 200127 • Helena MT • 59620-0127

1-800-287-8266 or 444-7462 in Helena

www.state.mt.us/doa/spd/benefits/healthbenefits.asp

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN

Blue Cross/Blue Shield of Montana • 1-800-423-0805 or 444-8315
www.bluecrossmontana.com

New West Health Plan • 1-800-290-3657 or 457-2200
www.newwesthealth.com

Peak Health Plan • 1-866-368-7325
www.healthinfonetmt.com

MEDICAL RATES

Monthly Premiums	Traditional	Blue Choice	Peak	New West
Employee	$425	$412	$409	$377
Employee & spouse	$597	$574	$580	$539
Employee & children	$551	$531	$537	$499
Employee & family	$625	$600	$606	$564
Joint Core	$485	$469	$475	$442

MEDICAL PLAN COSTS

Annual Deductible*
(Applies to all services, unless otherwise noted or a co-payment is indicated)

Coinsurance Percentages
General
Preferred Facility Services *(See page 34 & 35 for a list of preferred facilities)*
Nonpreferred Facility Services *(See page 34 & 35 for a list of non-preferred facilities)*

Annual Out-of-Pocket Maximums*
(Maximum coinsurance paid in the year; excludes deductibles and copayments)

***You pay deductible and coinsurance on allowable charges only (see Glossary on page 4).**

MEDICAL PLAN SERVICES

Hospital Services
(Inpatient services must be certified. Pre-certification is strongly recommended.)

Room Charges

Ancillary Services

Surgical Services

Outpatient Services

BENEFIT YEAR 2005

MEDICAL LIFETIME MAXIMUMS

Each Plan has a set maxiumum payable. This maximum is per person, per lifetime. The amounts shown below are the amounts that the plan would pay on an individual.

Traditional Plan: $1,000,000 lifetime maximum; Additional $2,000 available annually after the lifetime maximum is met.

Managed Care Plans: $1,000,000 lifetime maximum; Additional $2,000 available annually after the lifetime maximum is met.

TRADITIONAL PLAN	MANAGED CARE BENEFIT PLANS BLUE CHOICE - Administered by Blue Cross/Blue Shield of MT NEW WEST - Administered by New West Health Plan PEAK - Administered by Peak Health Plan	
Administered by BCBS	**In-Network Benefits**	**Out-of-Network Benefits**
$550/Member $1,650/Family	$400/Member $800/Family	Separate $500/Member Separate $1,000/Family
25% 20% 35%	25%	35%
Average of $2,500/Member *(20% - 35% of $10,000 in allowable charges)* Average of $5,000/Family *(20% - 35% of $20,000 in allowable charges)*	$2,000/Member $4,000/Family	Separate $2,000/Member Separate $4,000/Family
Coinsurance:	**Coinsurance/Copayment:**	**Coinsurance:**
20% - 35%	25%	35%
20% - 25%	25%	35%
20% - 25%	25%	35%
20% - 35%	25%	35%
20% - 35%	25%	35%

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN COSTS

Physician Services

Office Visits

Inpatient Physician Services

Lab / Ancillary / Miscellaneous Charges

Allergy Shots

Emergency Services

Ambulance Services for Medical Emergency

Emergency Room

Hospital Charges

Professional Charges

Urgent Care Services

Facility / Professional Charges

Lab & Diagnostic Charges

Maternity Services

Hospital Charges

Physician Charges

Prenatal Office Visits

Routine Newborn Care

Inpatient Hospital Charges

Preventive Services

Adult Exams and Tests
Mammogram, gyno exam and pap, proctoscopic and colonoscopic exams, PSA tests, bone density tests

Adult Immunizations (Pneumonia and Flu)

Child Checkups and Immunizations

Mental Health Services

Inpatient Services
(Inpatient services must be certified. Pre-certification is strongly recommended.)
Max: One inpatient day may be exchanged for two partial hospital days.

Outpatient Services

With EAP counselor referral

With NO EAP counselor referral

BENEFIT YEAR 2005

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
25% (no deductible for first two non-routine office visits)	$15/visit (no deductible some lab & diagnostic included)	35%
25%	25%	35%
25%	25%	35%
25% (no deductible)	$15/visit	35%
25%	$100 copay	$100 copay
20%-35%	$75/visit for facility charges only (waived if inpatient hospital or out-patient surgery coinsurance applies)	$75/visit for facility charges only
25%	25%	25%
25%	$25/visit	$25/visit
25%	25%	35%
20% - 35%	25%	35%
25%	25%	35%
25%	$50 global copay for **routine labs & office visits**	35%
20% - 35% (no deductible)	25%	35%
25% (no deductible) **Max**: 2 bone density tests/lifetime **Max**: $500 for colonoscopy, sigmoidoscopy, or proctoscopy	$15/visit (periodic physicals covered, including PSA, PAP, basic blood panel, and other limited lab work) $0 co-pay for mammogram 25% for bone density scan, sigmoidoscopy, colonoscopy, proctoscopy	35%
Not covered	$15 with office visit 25% (no deductible) without office visit	35%
25% (no deductible) 0% (no deductible for County Health Department through age 5)	$15/visit **Max**: Academy of Pediatrics Definitions *(through age 18)*	35%
20% - 35% 21 days *(No max for severe conditions)*	25% 21 days *(No max for severe conditions)*	35% 21 days *(No max for severe conditions)*
25% **Max**: 40 visits *(No max for severe conditions)*	$15/visit **Max**: 30 visits *(No max for severe conditions)*	35% **Max**: 30 visits *(No max for severe conditions)*
50% **Max**: 20 visits *(No max for severe conditions)*	$15/visit **Max**: 30 visits *(No max for severe conditions)*	35% **Max**: 30 visits *(No max for severe conditions)*

ANNUAL BENEFIT PLAN SUMMARY

MEDICAL PLAN COSTS

Chemical Dependency

Inpatient Services*
(Inpatient services must be certified. Pre-certification is strongly recommended.)

Outpatient Services*
With EAP counselor referral

With NO EAP counselor referral

*Dollar max for all Chemical Dependency Services: Combined inpatient/outpatient max of $6,000/year; $12,000/lifetime; $2,000/year after max is met.

Rehabilitative Services

Physical, Occupational, Cardiac, Pulmonary, and Speech Therapy
Inpatient Services
(Inpatient services must be certified. Pre-certification is strongly recommended.)

Outpatient Services – Hospital

Outpatient Services – Non-Hospital

Alternative Health Care Services

Acupuncture

Naturopathic

Chiropractic

Extended Care Services

Home Health Care
(Physician ordered/prior authorization recommended)

Hospice

Skilled Nursing

Miscellaneous Services

Dietary/Nutritional Counseling
(When medically necessary and physician ordered)

Durable Medical Equipment, Appliances, and Orthotics
(Prior authorization required for amounts over $500)

PKU Supplies

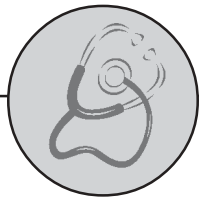
Organ Transplants

(Must be certified. Pre-certification is strongly recommended.)
Transplant Services
Lifetime Maximums:

BENEFIT YEAR 2005

TRADITIONAL PLAN	MANAGED CARE IN-NETWORK	MANAGED CARE OUT-OF-NETWORK
20% - 35%	25%	35%
25% **Max**: 40 visits and Dollar Limit*	$15/visit **Max**: Dollar Limit*	35% **Max**: Dollar Limit*
50% **Max**: 20 visits and Dollar Limit*	$15/visit **Max**: Dollar Limit*	35% **Max**: Dollar Limit*
20% - 35% **Max**: 60 days	25% **Max**: 60 days	35% **Max**: 60 days
20% - 35% **Max**: $2,000/year for all outpatient ($10,000/year for prior-auth. conditions)	$15/visit **Max**: 30 visits	35% **Max**: 30 visits
25% **Max**: $2,000/year for all outpatient ($10,000/year for prior-auth. conditions)	$15/visit **Max**: 30 visits	35% **Max**: 30 visits
25% (plus charges over $30/visit)	Not covered	Not covered
25% (plus charges over $30/visit)	Not covered	Not covered
25% (plus charges over $30/visit) **Max**: 25 visits in any combination for alternative health care	$15/visit **Max**: 20 visits	Not covered
25% **Max**: 70 days	$15/visit **Max**: 30 visits	35% **Max**: 30 visits
25% (20% - 35% if hospital-based) **Max**: 6 months	25% **Max**: 6 months	35% **Max**: 6 months
25% (20% - 35% if hospital-based) **Max**: 70 days	25% **Max**: 30 days	35% **Max**: 30 days
20% - 35% **Max**: $250	$15/visit	35%
25% **Max**: $100 for foot orthotics (per foot)	25% (Not applied to out-of-pocket max) **Max**: $100 for foot orthotics (per foot)	35% **Max**: $100 for foot orthotics (per foot)
25%	Plan pays for 100% for services required under State mandate.	35%
25% • Liver: $200,000 • Heart: $120,000 • Lung: $160,000 • Heart/Lung: $160,000 • Bone Marrow: $160,000 • Pancreas: $68,000 • Cornea/Kidney: No maximum	25% $500,000 lifetime maximum with $5,000 of the maximum available for travel to and from the facility.	Not covered

MEDICAL INSURANCE PLANS - 2005



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WHO IS ELIGIBLE?

Employees, Legislators, retirees, and COBRA members of the State Benefit Plan are eligible for the Medical Insurance Plan. Enrollment is only allowed during these circumstances:

- within a new employee's initial 31-day enrollment period;
- within 63 days of becoming a dependent (through marriage, birth, adoption, pre-adoption, or court-ordered custody/legal guardianship);
- within 63 days of losing eligibility (not cancellation) for other group coverage;
- within 63 days of losing an employer's contribution toward other group coverage, sustaining a major increase in out-of-pocket costs, or losing benefits.

Notify your Agency Insurance Personnel when one of the above circumstances occurs (within the specified time-frames) to enroll dependents.

CLICK ON IT!

Learn more about your insurance administrator's customer service by visiting their web site at:

www.bluecrossmontana.com

www.newwesthealth.com

www.healthinfonetmt.com

INSTRUCTIONS

1. Read about each plan in the General Information section on this page.
2. Review and compare each plans' costs and services in the Benefits Summary, starting on page 6.
3. Review your typical health care needs and look at the Cost Comparisons on page 13.
4. If you are considering a managed care plan, review the Managed Care Areas section on pages 31 through 33, and the provider directories beginning on page 36.
5. Determine which plan will work best for your family. Make your selection by completing Parts 1 & 4 of the Enrollment/Change form.

Employee Group Benefits Enrollment/ Change Form Parts 1 & 4

GENERAL INFORMATION

The State of Montana offers an indemnity insurance plan and three managed care plans to choose from:

- **Traditional Indemnity Plan**
- **Blue Choice**
- **New West Health Plan**
- **Peak Health Plan**

TRADITIONAL PLAN

The Traditional Indemnity plan is administered by Blue Cross and Blue Shield of Montana (BCBS), which processes claims and payments, provides customer service and notice to members in the form of an Explanation of Benefits (EOB). BCBS also contracts with health care providers to offer plan members a provider network – providers who have agreed to accept certain plan allowances.

How The Plan Works

Plan members obtain medical services from a covered health care provider. If the provider is a BCBS provider, he or she will submit a claim for the plan member. BCBS will then process the claim and send an EOB to the plan member, indicating their payment responsibilities (deductible and/or coinsurance costs) to the provider. The Plan then pays the remaining allowable charges, which the provider accepts as full payment. **Please verify a provider is currently participating by calling BCBS.**

If the provider is not a BCBS provider, you may be required to pay the entire fee and file a claim for reimbursement. There may be unallowed charges which you will have to pay.

Preferred Facility Services

Plan members may obtain covered medical services from any covered hospital. However, certain hospitals and surgical centers offer services for members on the Traditional plan that are subject to lower coinsurance rates. Please refer to the Participating Facilities section on page 34 for a list of these facilities. For your protection, it is strongly recommended to pre-certify all inpatient hospital services by calling your plan's customer service phone number, listed at the top of this page.

Out-of-State Services

The Blue Card Program lets plan members tap into BCBS plan networks in other states. If the out-of-state BCBS plan includes "hold harmless" provisions, the member will not be responsible for balances above the allowable amount.

MANAGED CARE PLANS

Blue Choice, New West, and Peak Health are managed care plans offered through the Montana Association of Health Care Purchasers, a purchasing pool of which the State is a member. The plans generally provide the same package of benefits, but there are differences in costs and requirements for receiving services.

How They Work

The benefits of managed care plans depend on the health care provider the member uses. When a network provider is used, the in-network benefits apply. When an out-of-network provider is used, out-of-network benefits apply (unless a required referral/authorization is obtained).

In-Network Benefits

When joining a managed care plan, members choose a Primary Care Physician (PCP) who is a member of the plan's network providers. The PCP oversees the member's care. A referral/authorization is not required for the plan member to see an in-network specialist. Referrals/authorizations **are** required to see an out-of-network specialist and still receive the plan's in-network benefits.

Out-of-Network Benefits

When plan members obtain services from providers who are not part of the plan's network, with no required referral / authorization, costs will be more because a separate and higher deductible, a higher coinsurance rate, and a separate out-of-pocket maximum apply.

Out-of-State Services

Plan members may receive in-network benefits for medical services in other states for a medical emergency. For non-emergency services out-of-state, please contact your plan administrator for specific provider network information.

SERVICE AREAS

The Traditional Plan is available to members living anywhere in Montana or throughout the world. The plan includes services of any covered providers. However, providers who are not BCBS member providers may charge more for a service than the plan allows, leaving you responsible for paying the difference.

IMPORTANT!
BCBS providers for the Traditional plan are different than the BCBS providers for the Blue Choice plan. A provider may be a member provider on one or both plans.

The managed care plans – Blue Choice, New West Health Plan, and Peak Health Plan – are available to members living in certain areas in Montana. Please see pages 31-33 for a complete listing of covered zip codes for each plan.

Blue Choice

This plan is available in most of Western Montana (except Bozeman) and many other towns including Billings, Great Falls, and Havre.

New West Health Plan

This plan is available in most of Western Montana and many other towns including Billings, Great Falls, Havre, and Miles City.

Peak Health Plan

This plan is available to members in Billings, Butte, Deer Lodge, and the surrounding communities.

MEDICAL INSURANCE COST COMPARISONS

The following medical insurance cost comparisons show how each plan would process the same service, and what costs the plan member would be responsible for paying. The example is **cumulative** with respect to deductibles and coinsurance. The first line of each example shows the total costs to the member. The next three lines show how that cost is divided between copays, costs applied to the deductible, and coinsurance costs. It does not include premium costs, which are outlined on page 6. These examples assume the services were for one member. This is simply an example for ease of plan comparison and is not a guarantee that similar services will process identically.

EMPLOYEES			TRADITIONAL	MANAGED CARE PLANS	
Sample Services	**Allowable Charge**			**In-Network**	**Out-of-Network**
Office visits 1, 2, & 3 ($50 each)	**$150**	**You pay ➡**	**$75**	**$45**	**$150**
Copay costs				$45 ($15/each)	
Costs applied to deductible			$50*		$150
Coinsurance costs			$25		
Lab charges with office visit 1	**$75**	**You pay ➡**	**$75**	**$75**	**$75**
Copay costs					
Costs applied to deductible			$75	$75**	$75
Coinsurance costs					
Specialist visit (i.e. dermatologist)	**$200**	**You pay ➡**	**$200**	**$15**	**$200**
Copay costs				$15	
Costs applied to deductible			$200		$200
Coinsurance costs					
Preferred hospital inpatient	**$8,500**	**You pay ➡**	**$1,880**	**$2,325**	**$2,075**
Copay costs					
Costs applied to deductible			$225	$325	$75
Coinsurance costs			$1,655	$2,000	$2,000
Nonpreferred hospital inpatient	**$8,500**	**You pay ➡**	**$3121**	**N/A**	**N/A**
Copay costs					
Costs applied to deductible			$225		
Coinsurance costs			$2,896		

*First two office visits are exempt from the deductible.
**May be included in office co-payment